Congress of the United States
House of Representatives
Washington, DC 20515

Ms. Charlene Frizzera
Acting Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

March 6, 2009

Dear Ms. Frizzera:

We commend CMS for proposing significant policy changes in the 2010 draft Call Letter that strengthen protections for Medicare beneficiaries in the Medicare Advantage (MA) and Part D programs. In particular, we appreciate CMS' proposed policies to prevent discriminatory MA benefit designs, increase transparency and accountability of private fee-for-service (PFFS) plans, reduce beneficiary confusion in Part D, and protect beneficiaries against unfair marketing practices. Below we outline provisions of the draft Call Letter that we support, and suggest additional policies that we think CMS should consider for the final Call Letter or future regulatory action. We recognize that there are limits to CMS' regulatory authority and understand that Congressional action may be necessary to fully protect beneficiaries enrolled in the Medicare Advantage and Part D programs.

Medicare Advantage Benefit Design

CMS is taking important steps to eliminate MA benefit designs that discriminate against sicker beneficiaries through high cost-sharing for particular services. A February 2008 GAO report found that 16 percent of MA beneficiaries were in plans that projected higher cost-sharing for inpatient services than under Medicare fee-for-service and 19 percent were in plans that projected higher cost-sharing for home health services. GAO also found that beneficiaries who frequently used these services could have had overall higher cost-sharing in Medicare Advantage than under Medicare fee-for-service. We are pleased that CMS has taken steps such as discouraging plans from applying extra coinsurance to certain services used by sicker beneficiaries and clarifying the use of incentives that plans offer to encourage enrollees to use preventive services. These steps will help prevent approval of plan benefit packages designed to cherry-pick healthy beneficiaries.

You asked for comment on CMS' proposed cost-sharing policies. We believe that CMS should add home health to the list of services that it will scrutinize if plans apply coinsurance or do not have a $3,400 out-of-pocket (OOP) maximum.

Other MA provisions that we encourage CMS to consider – either in the final Call Letter or in regulation – including limiting cost-sharing by service to a percentage of cost-sharing levels in Original Medicare, requiring plans to include an OOP maximum, and increasing scrutiny of plans with cost-sharing that varies significantly across benefit categories.

Private Fee-for-Service

We appreciate CMS' efforts to improve transparency and accountability in the PFFS program. We agree with CMS that scrutiny of the use of pre-notification incentives is crucial and strongly support CMS' additional provisions in the draft Call Letter to limit plans' use of prior notification, to ensure that beneficiaries are notified of the voluntary prior notification requirement, and to provide additional scrutiny on the cost-sharing applied to make sure it is not discriminatory and meets an actuarial value test.

You asked for comment on whether PFFS plan benefit structures that include lower cost-sharing for prior notification should be prohibited. We strongly urge CMS to prohibit the use of pre-notification incentives for PFFS plan enrollees. A December 2008 GAO report found that a PFFS plan increased coinsurance from 30 percent to 70 percent for durable medical equipment if beneficiaries or their providers did not pre-notify the plan; some plans increased cost-sharing by $50 per day up to $500 for inpatient mental health stays, skilled nursing facility stays and inpatient hospital stays if beneficiaries did not pre-notify the plans. We believe that prior notification is very similar to prior authorization – which is prohibited for PFFS plans – and imposes a substantial burden on beneficiaries. At a minimum, we encourage CMS to ensure that the default cost-sharing (the level applied in the absence of prior notification) is not excessive or onerous and does not discriminate against beneficiaries with serious health conditions.

We support the creation of an independent review entity (IRE) to address provider payment disputes and encourage CMS to consider imposing timelines that the IRE will enforce for resolving these disputes.

Part C and Part D Data Auditing Requirements

GAO, HHS IG, and other analysts have identified significant data quality problems with information reported to CMS by providers under Part C and Part D. New requirements that MA plans, cost plans, and Part D sponsors conduct self-audits of data reported to CMS will provide a valuable check on information reported to the agency. However, it is critical that CMS not allow these self-audits to become the sole or primary means of program compliance, and that CMS conduct aggressive plan oversight through other mechanisms.

Part D Benefit Design and Formulary

CMS has proposed important steps to reduce beneficiary confusion around Part D. We support CMS' proposal to use standardized thresholds for defining coverage in the gap, for both brand and generic drugs. CMS could take further steps to simplify the benefit design by requiring that plans cover all generics, all brands, or no drugs in the coverage gap, and include these definitions in the benefit descriptions. We would recommend that CMS explore whether other simple measures of gap coverage – such as the estimated percentage of prescriptions covered, or the estimated percentage of total drug costs covered – may provide more meaningful information to beneficiaries than the simple percentage of drugs covered in the gap. We also commend CMS' proposal to eliminate the use of reference-based pricing in Part D because of the potential confusion for beneficiaries – particularly vulnerable populations – about their true out-of-pocket costs.

Additionally, we strongly encourage CMS to take further actions to protect beneficiaries. These actions may include limiting the cost-sharing for specialty tiers to 25 percent, and moving the Part D benefit toward a more standardized format by requiring plans to label formulary tiers, identify which enhanced benefits they provide, and include more detail on the formulary about the use of quantity limits. We recognize that certain measures would require regulatory action, and we encourage CMS to consider changes in both the final Call Letter and in regulation.

Enhanced Utilization Management Criteria and Medication Therapy Management Program Requirements

We support CMS' efforts to clarify utilization management reporting requirements and to expand access to medication therapy management (MTM) programs and implement MTM best practices, and encourage CMS to require that all PFFS plans offer an MTM program. We are also pleased to see that CMS has proposed objective outcomes measurement requirements for MTM programs.

Part D Retroactive Reimbursement for Low-Income Individuals

In 2007, the GAO found that CMS does not monitor its payments to Part D plans for retroactive coverage of dual eligibles or the amounts plans have reimbursed these beneficiaries. We understand that there are still plans that do not have processes in place for correctly handling retroactive reimbursement. Thus, CMS should reiterate its policy in the final Call Letter that plans must reimburse beneficiaries who are enrolled in their plans and later determined to be Low-Income Subsidy (LIS) beneficiaries automatically and without further documentation or action from the beneficiary. When a reimbursement is not made automatically and a request for reimbursement must be made, that request should be treated as a coverage determination, which requires plans to make a determination within 72 hours of receiving the request and issue payment within 30 days. Plans should not require beneficiaries to use particular claim forms when requesting an LIS reimbursement. Beneficiaries should be reimbursed within 30 days, not quarterly or annually. Plans must explain to beneficiaries, in a consumer friendly manner, the reason for the reimbursement. CMS should make clear to the plans that the

responsibility to provide this reimbursement resides ultimately with the plan and that a plan's contracts with prescription benefit managers (PBM) must be modified to reflect these requirements. Any failure of a PBM intermediary to fulfill its duties under such a contract should be treated as a failure of the plan to comply with these requirements.

Finally, plans are obligated to have a process to determine when a State Pharmacy Assistance Program or other third party payer is owed money and reimburse the beneficiary and third party payer accordingly.

We also support CMS' demonstration project that will assign new full benefit dual eligible individuals with retroactive coverage to a single contractor, as this process will make it significantly easier to track retroactive payments and resolve eligibility issues.

Response to Complaint Times

We support the new CMS draft proposal to require that at least 95 percent of urgent need complaints be resolved within 7 calendar days of receipt, and that at least 95 percent of all other complaints be resolved within 30 calendar days of receipt, and agree that Part D sponsors that are unable to meet these criteria should be considered out of compliance with relevant Part D requirements.

Medical Loss Ratio

We appreciate that CMS asked for comments on how to calculate Medical Loss Ratios (MLRs) and encourage CMS to release MLRs to the public once a clear definition is reached. MLRs provide a good measure for beneficiaries to compare plans, and are a valuable tool for other stakeholders to use in evaluating plan performance and value. It is imperative that CMS create clear distinctions between medical benefits and administrative costs so that MLRs are a useful, uniform measure across the industry. We suggest that CMS also distinguish between medical benefits for fee-for-service and supplemental benefits. In addition, please consider distinguishing between administrative expenses for marketing and sales, direct administration, indirect administration, and the net cost of private insurance. In considering MLR calculation, we suggest that disease management and/or care coordination activities that improve quality of care should also be distinguished among administrative and medical costs. We think it is important to distinguish between these activities and other benefit administration functions. MLRs are one way that beneficiaries could be made aware of the plans that engage in these activities in a way that adds value.

Additionally, we believe that plan expenditures for directly and indirectly (e.g. outreach to encourage members to contact Congress) communicating with Congress or other lobbying about the MA or Part D program cannot legitimately be included as administrative costs in the plan's bid to CMS. The federal government should not be paying for plans' lobbying efforts.

Marketing

Recent news about violations by WellCare and WellPoint, two of the largest plans in the MA and Part D markets, highlight the urgency for clear and consistent regulation by CMS that ensures beneficiary protection. CMS continues to make important efforts to regulate MA and Part D plans' marketing activities and we acknowledge the proposals in the draft Call Letter to restrict exorbitant payments to agents for referrals. We also suggest that CMS consider requiring that plans marketing to populations in languages other than English translate the relevant documents into the targeted languages.

In general, we want to commend CMS for its vision and strong commitment to strengthening the MA and Part D programs for enrollees and encourage you to maintain those protections in the final Call Letter. Many of CMS' proposals in the 2010 draft Call Letter will improve transparency and stem discriminatory practices. However, we hope that CMS will seriously consider our additional proposals outlined above around benefit and formulary design, transparency, marketing and MLRs.

Sincerely,

Charles B. Rangel
Chairman
Committee on Ways and Means

Henry A. Waxman
Chairman
Committee on Energy and Commerce

Pete Stark
Chairman
Committee on Ways and Means
Subcommittee on Health

Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
Subcommittee on Health

John D. Dingell
Chairman Emeritus
Committee on Energy and Commerce